Mental Health, Developmental Disabilities and Substance Abuse Services
Statewide System Performance Report
SFY 2012-13: Spring Report

NC General Statute 122C – 102

April 1, 2013

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Executive Summary

The General Statute continues to require the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the Division) to report to the Joint Legislative Oversight Committee on Health and Human Services every six months on progress made in seven statewide performance domains. This semi-annual report builds on the measures in the previous reports.

Domain 1: Access to Services –The Division measures the number of individuals actually receiving services (penetration) against the number of individuals projected to have a mental illness, intellectual or developmental disability or substance use disorder based upon national prevalence rates. Half of children (50%) and adults (48%) estimated to have a mental illness are provided services by the public system. Approximately 18% of children and 38% of adults estimated to have developmental disabilities are provided services by the public system. Access to services for persons estimated to have substance abuse problems (9% of adolescents and 11% of adults in need) continues to be an area of significant concern.

Over the past two calendar years, the timeliness of initial services for routine care has fluctuated, reaching a high of 76% and a low of 69%.

Domain 2: Individualized Planning and Supports – Individuals with mental health and substance use disorders overwhelmingly report having a choice in their provider. Similar to individuals in other states, the majority of individuals with intellectual/developmental disabilities report having some input in how they spend their day, money and free time. In addition, the individuals with intellectual/developmental disabilities report their case managers are responsive to their needs.

For all disability groups, the large majority report being involved in service planning and treatment, with adolescents in substance abuse treatment reporting the lowest level of family involvement.

Domain 3: Promotion of Best Practices – The number of individuals receiving community mental health and substance abuse services that incorporate evidence-based practices has dropped in 2011 and 2012, as funding for community services has been reduced. The decrease has been greater for adult services than for child services.

Domain 4: Consumer-Friendly Outcomes – North Carolina residents with intellectual/developmental disabilities report slightly stronger participation in community life than individuals with I/DD in other states. More parents and guardians of children (ages 6-11) receiving mental health services reported services being very helpful in key quality of life indicators than adolescents (ages 12-17) receiving mental health services. Compared to adults receiving mental health treatment, adults in substance abuse treatment were more likely to report that services were very helpful in improving their education, housing, and employment.

Domain 5: Quality Management Systems – As part of the continued expansion of the 1915 (b)/(c) Medicaid Waiver, the Department has contracted with the Carolina Center for Medical Excellence to provide an independent quality review of the activities and data of the new LME/MCOs. The Department is also requiring the LME/MCOs to adopt the Gold Star Rating system to monitor and evaluate the quality of their provider networks.

Domain 6: System Efficiency and Effectiveness – The timely and accurate submission of data to the Division has declined in the last quarters, decreasing from 87% to 80%. The submission of reports to the Division has also declined this past quarter to 87%; though previously remained consistently high, fluctuating between 91% and 100%.

LMEs have been very successful in meeting contracted performance expectations for engaging substance abuse consumers in treatment and in reducing acute and repeated admissions to state facilities. However, fewer LMEs have met expectations for providing timely follow-up care for those discharged from state facilities.

Domain 7: Prevention and Early Intervention – The Controlled Substances Reporting System (CSRS), a prescription monitoring program, was legislated in 2005 and implemented in 2007 in response to the nationwide epidemic of prescription drug overdoses. It requires all prescriptions for controlled substances to be reported within one week of being dispensed and allows prescribers and dispensers to check the database to insure patients are not receiving multiple prescriptions from numerous resources. This feature helps to prevent NC residents from being prescribed potentially lethal amounts or dangerous combinations of medications. Since implementation, there has been a steady increase in practitioners using the CSRS and in admissions to treatment for persons using controlled substances.

Effective prevention and early intervention programs present significant opportunities to reduce the burden of problem gambling. Among individuals seeking assistance, more problems (42%) were related to playing sweepstakes and video poker than other games. The NC Problem Gambling Program offers awareness and prevention programs to students at North Carolina middle schools, high schools and colleges to address problems at an early stage.

Caution for Interpreting This Report: In SFY 2011-2012, the state continued expansion of its Medicaid 1915 (b)/(c) waiver using a managed care approach to providing mental health, developmental disabilities, and substance abuse services to Medicaid recipients. Over the course of SFY 2011-2012, Cardinal Innovations Healthcare Solutions (formerly called PBH) expanded to include Alamance-Caswell LME, Five County LME, and Orange-Person-Chatham LME. In addition, Western Highlands and East Carolina Behavioral Health LME became managed care organizations (MCOs). Six additional LMEs have begun operating under the waiver as of February 2013. As these changes occurred, Medicaid claims data for the LME/MCOs became temporarily unavailable to the state Medicaid claims database. This has affected results for some of the claims-based performance measures in this report. For some measures, partial data was used. For other measures, all data for an LME was excluded. Careful attention to footnotes and Appendices is warranted before interpreting the information presented. The state has taken steps to collect claims data for these LME/MCOs from the date they started operating under the waiver. Until this process is complete, care is recommended when comparing performance for this quarter to prior quarters.

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Mental Health, Developmental Disabilities and Substance Abuse Services
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Introduction

The *Mental Health, Developmental Disabilities and Substance Abuse Services Statewide System Performance Report* is presented in response to NC General Statute 122C - 102. This legislation requires this report on statewide progress in seven performance domains to be submitted to the Joint Legislative Oversight Committee on Health and Human Services every six months. This report builds on the measures reported in previous reports.

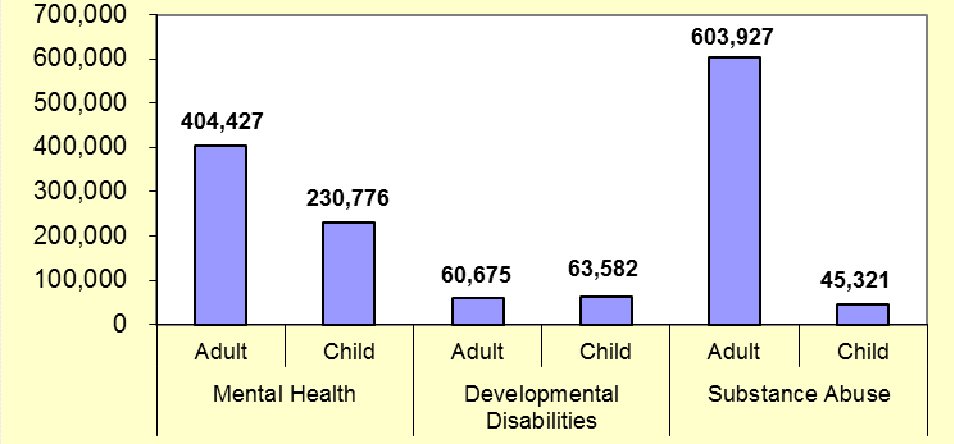
Domain 1: Access to Services

Access to Services refers to the process of entering the service system. This domain measures the system's effectiveness in providing easy and quick access to services for individuals with mental health, intellectual/developmental disabilities and substance abuse service needs who request help. It is a nationally recognized measure of service performance.

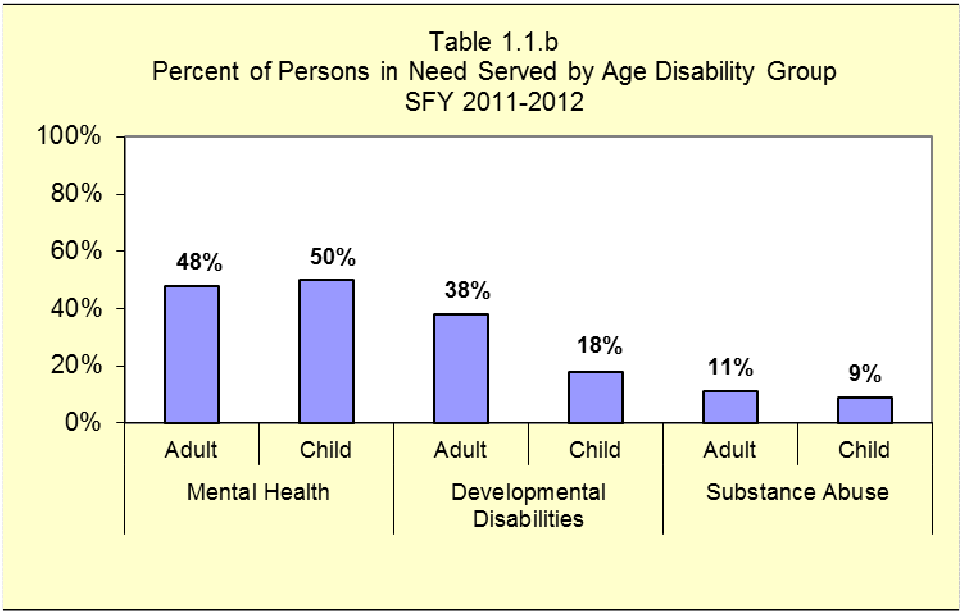
Measure 1.1: Persons In Need of and Receiving Community Services

This measure compares the number of persons estimated to be in need of mh/dd/sa services (Table 1.1.a) to those who received publicly-funded community-based services during the last state fiscal year (Table 1.1.b on the next page). The Division uses this information to establish reasonable targets and to evaluate the need for future changes to fiscal or programmatic policies.

Table 1.1.a
Number of Persons in Need of Services by Age Disability Group
SFY 2011-2012



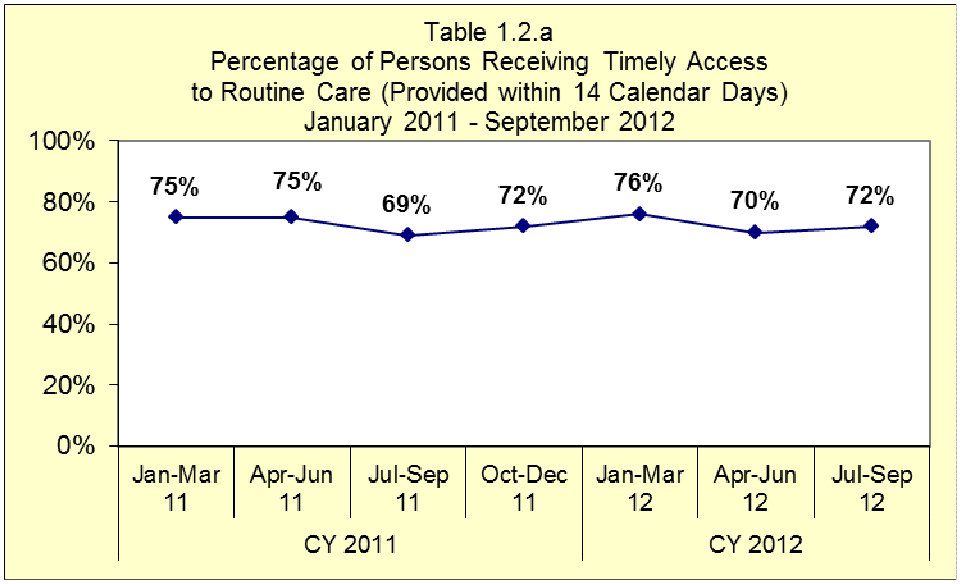
SOURCE: Office of State Budget and Management (OSBM) State Demographics Unit, May 8, 2012 population projection data. See Appendix A for prevalence estimate citations.



SOURCE: Medicaid and State Service Claims Data: July 1, 2011 to June 30, 2012 based on claims paid through October 31, 2012, as published in the *Community Systems Progress Report SFY 2012-13 First Quarter Report.* [1]

Measure 1.2: Timeliness of Initial Service

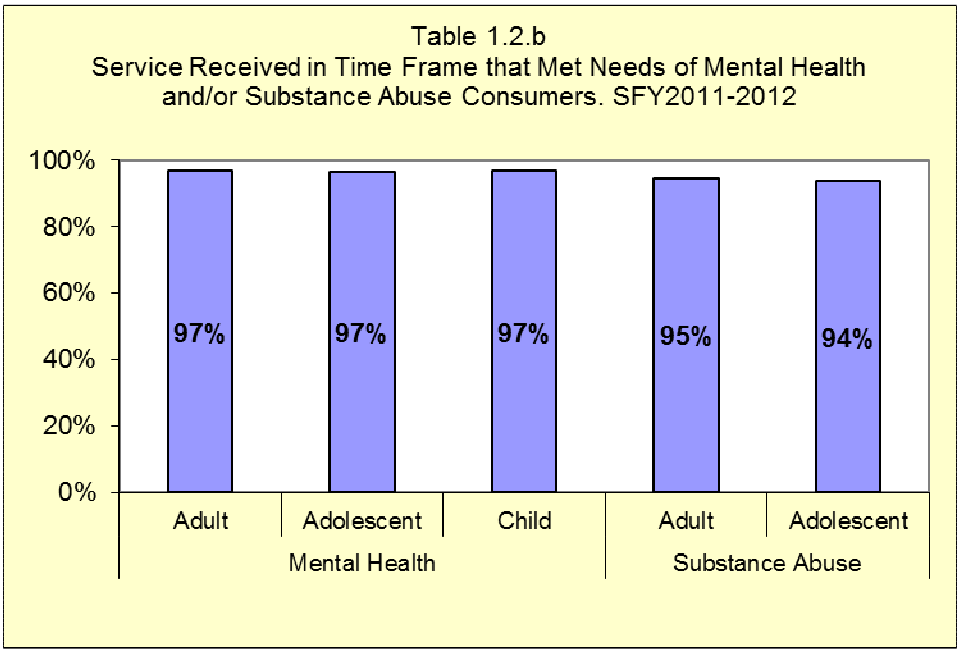
The time between an individual's call to request service and their first face-to-face service is a nationally accepted indicator[2] of the responsiveness of the service system, which can influence an individual's progress toward recovery and/or control over their life.



SOURCE: Data from LME/MCOs submitted to the NC Division of MH/DD/SAS.

[1] Medicaid claims data for Medicaid waiver sites is not included in the paid claims database. Data for Cardinal Innovations is self-reported. Data for LMEs that implemented the waiver during SFY 2011-12 does not include new persons served and paid by Medicaid after the waiver was implemented.

[2] Health Plan Employer Data and Information Set (HEDIS©) measures.



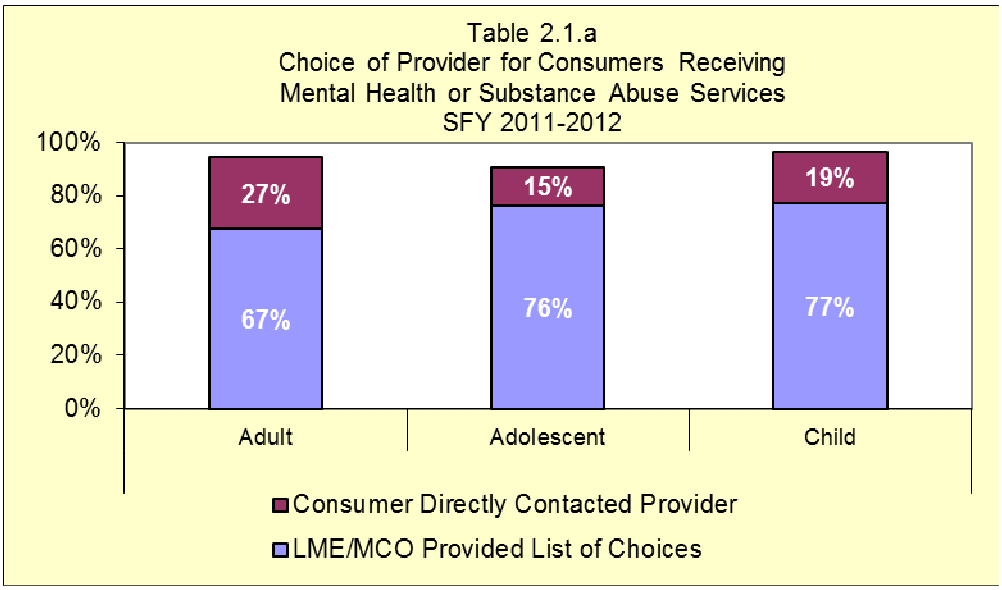
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2011 - June 30, 2012.

Domain 2: Individualized Planning and Supports

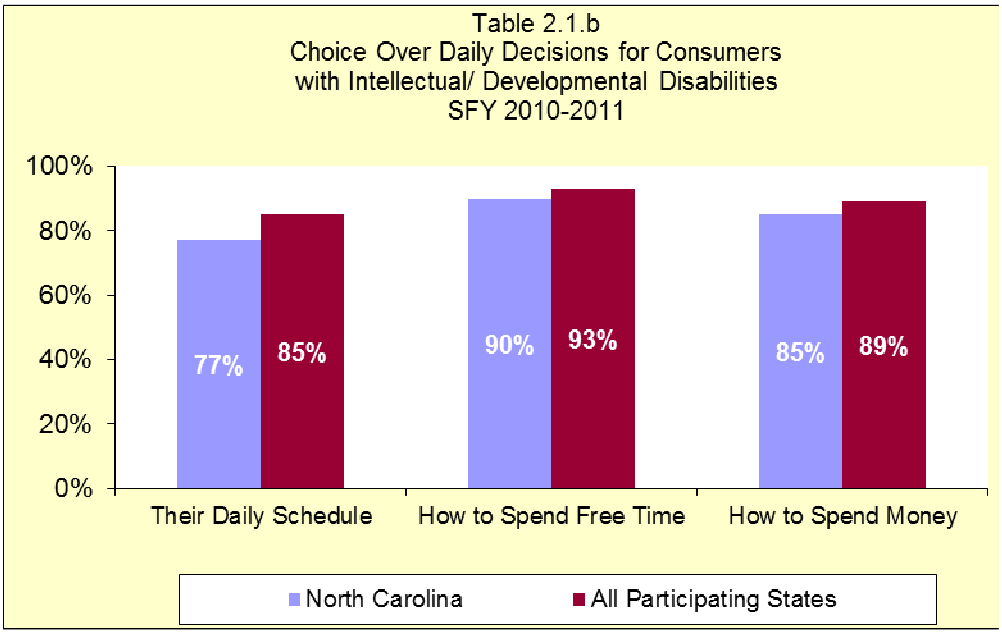
Involving individuals in decisions helps ensure that their services and supports address their personal needs and goals, which in turn assists them in achieving recovery and control over their lives.

Measure 2.1: Consumer Choice

Offering choice is the initial step in honoring the individualized needs of persons with disabilities.



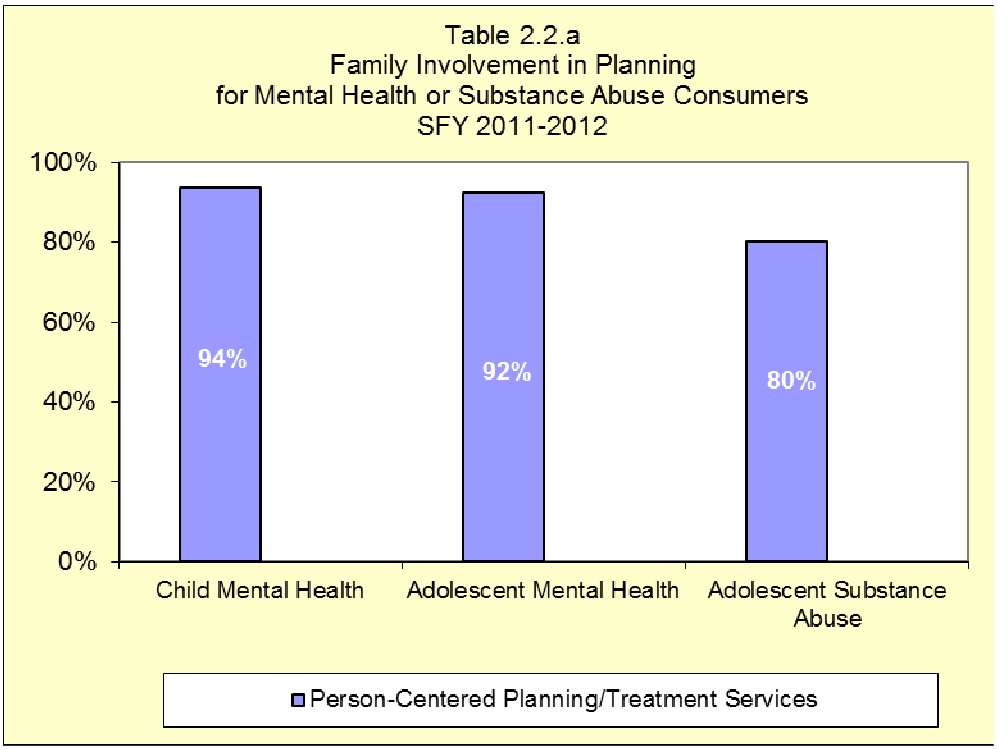
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2011 - June 30, 2012.



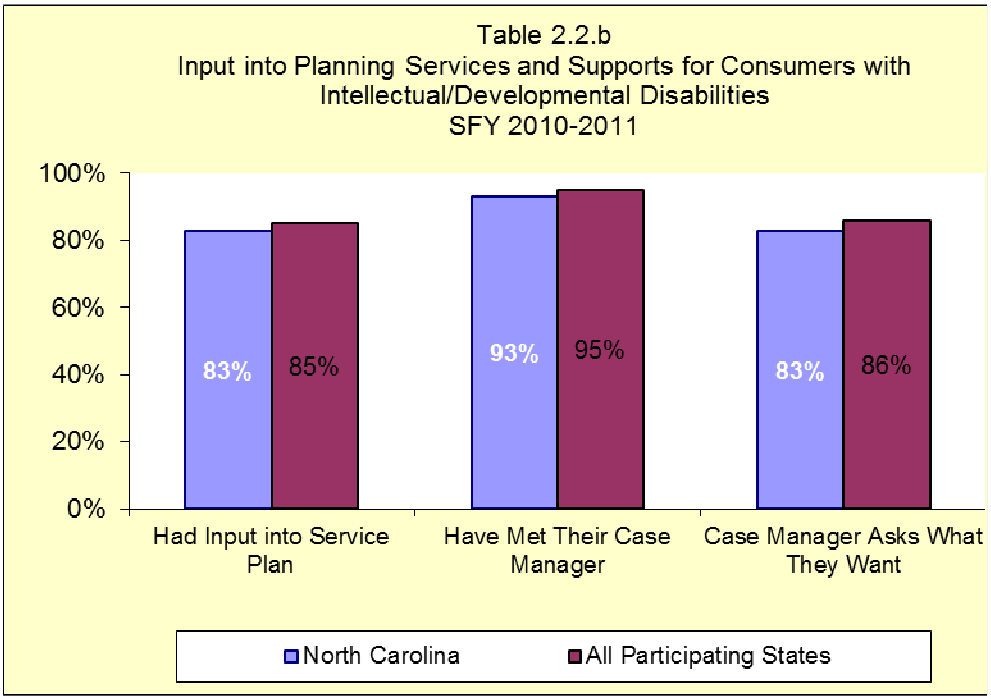
SOURCE: National Core Indicators State Report: North Carolina. Project Year 2010-11, North Carolina compared to All Participating States.

Measure 2.2: Person-Centered Planning.

Tables 2.2.a and 2.2.b show that the majority of individuals and/or their families are involved in the service planning and delivery process, increasing the chances that plans are tailored to an individual's needs and goals.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. 3 Month Update Interviews conducted July 1, 2011 - June 30, 2012



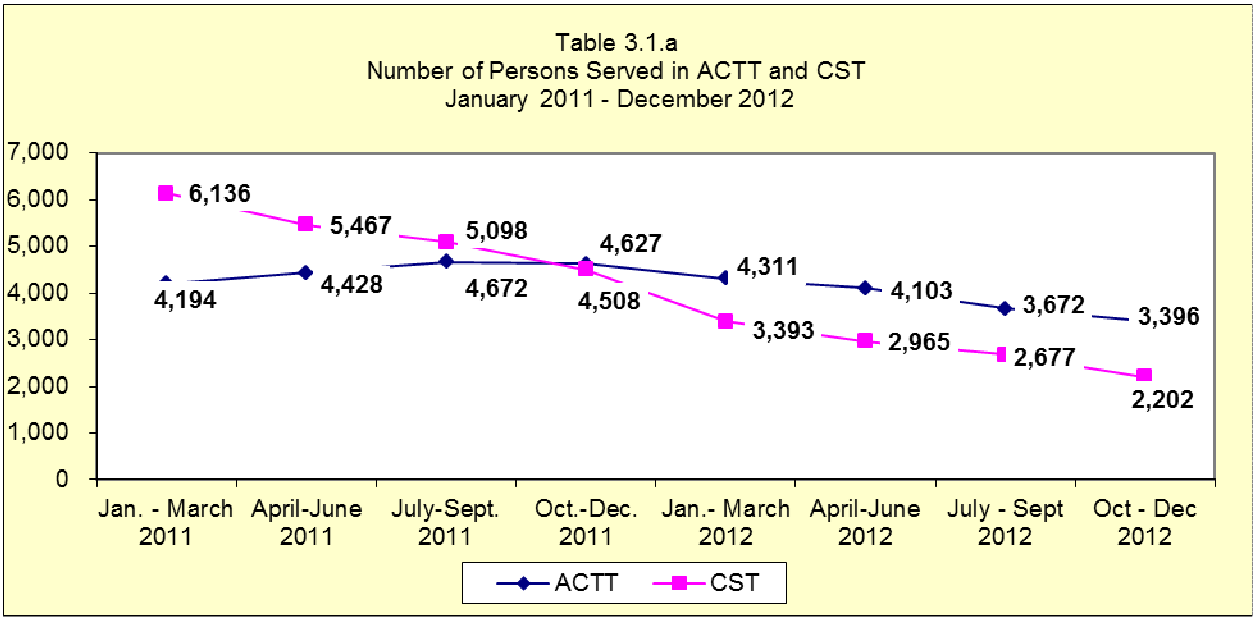
SOURCE: National Core Indicators State Report: NC Project Year 2010-11; compared to all States.

Domain 3: Promotion of Best Practice

Use of practices that research has shown to be effective helps to prevent crises, increase recovery, and supports individuals' ability to live successfully in their communities.

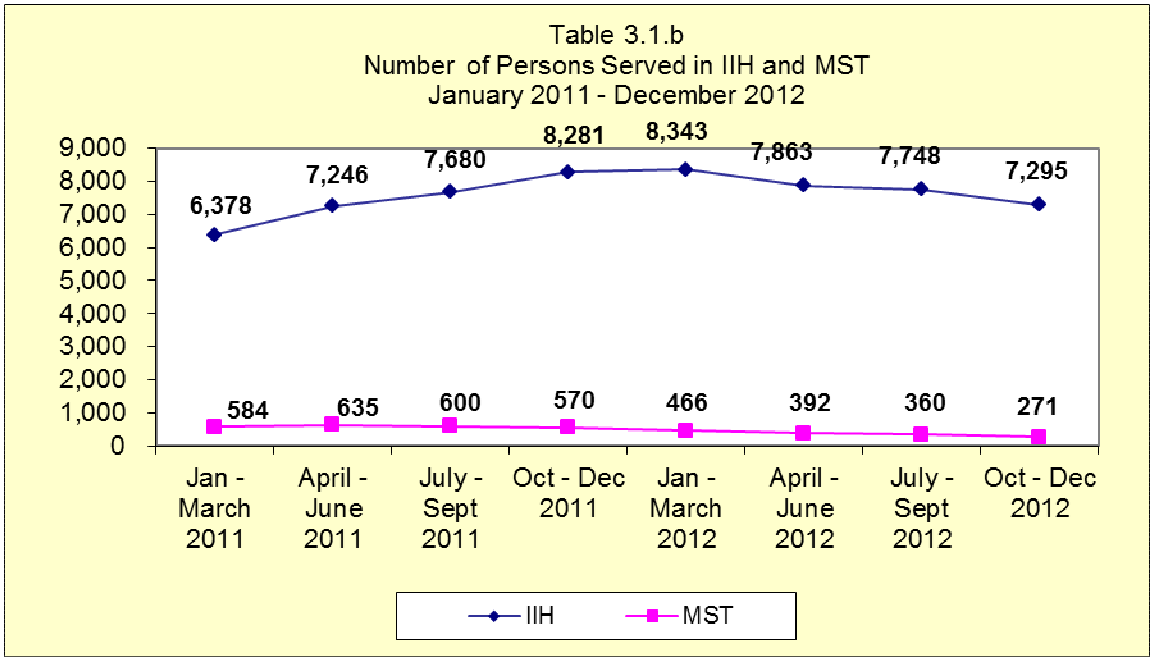
Measure 3.1: Persons Receiving Evidence-Based Practices

Assertive Community Treatment Teams (ACTT) and Community Support Teams (CST) provide intensive, wrap-around services to help prevent crises and need for hospitalization.



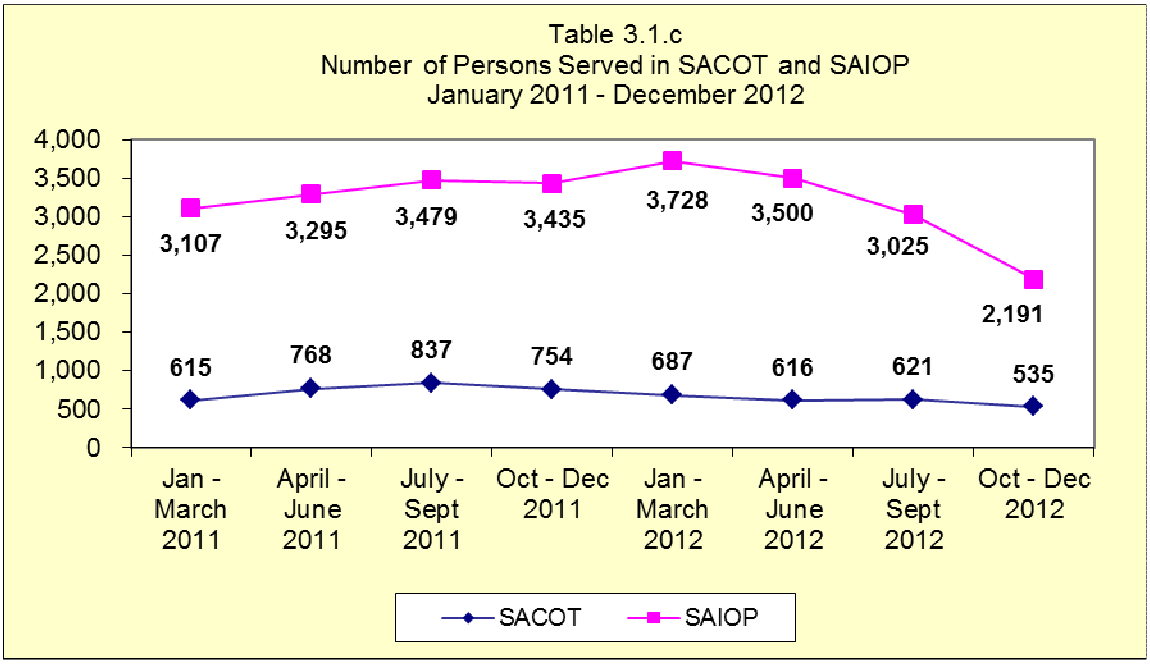
SOURCE: Medicaid and State Service Claims Data Jan. 1, 2011 – Dec. 31, 2012. Caution: Data for recent quarters is incomplete due to billing lag.

Intensive In-Home (IIH) and Multi-Systemic Therapy (MST) help reduce the number of children placed in inpatient and residential care.



SOURCE: Medicaid and State Service Claims Data Jan. 1, 2011 – Dec. 31, 2012. Caution: Data for recent quarters is incomplete due to billing lag.

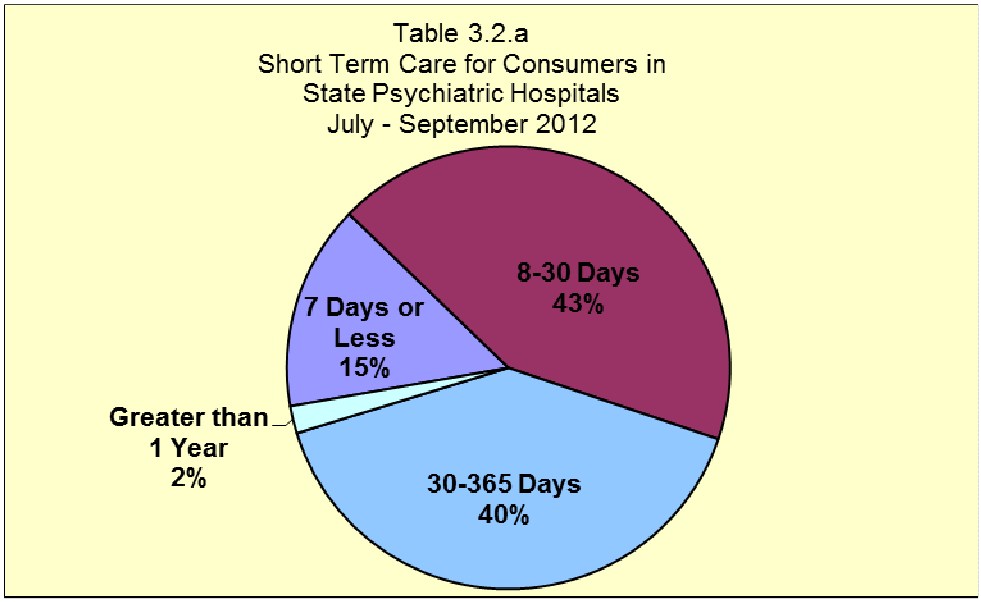
Substance Abuse Intensive Outpatient (SAIOP) and Substance Abuse Comprehensive Outpatient Treatment (SACOT) models support intensive services that use best practices, such as motivational interviewing.



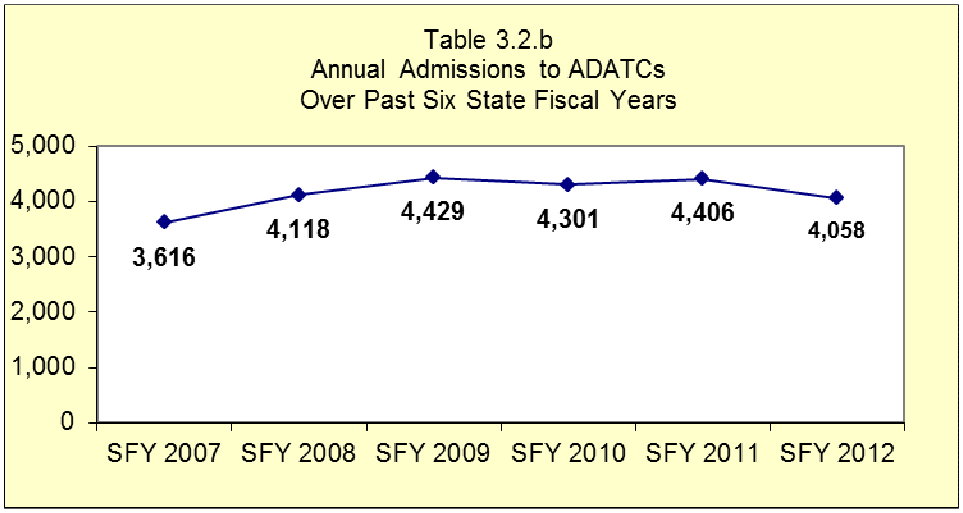
SOURCE: Medicaid and State Service Claims Data Jan. 1, 2011 – Dec. 31, 2012. Caution: Data for recent quarters is incomplete due to billing lag.

Measure 3.2: Use of State Facilities

State facilities are intended to help individuals who need services that cannot be provided in their home communities. The Division works to reserve state psychiatric hospitals for those who need long-term care, reducing the number of admissions for short term, acute care. The alcohol and drug treatment centers (ADATCs) are intended to provide inpatient treatment for persons with serious alcohol and drug disorders.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS)
Data for discharges during July 1 – September 30, 2012; N=616 discharges.



SOURCE: DMH/DD/SAS Consumer Data Warehouse (CDW), Annual Statistical. Reports for Alcohol and Drug Abuse Treatment Centers, admissions SFY 2007 through SFY 2012.

Measure 3.3: Transitions to Community

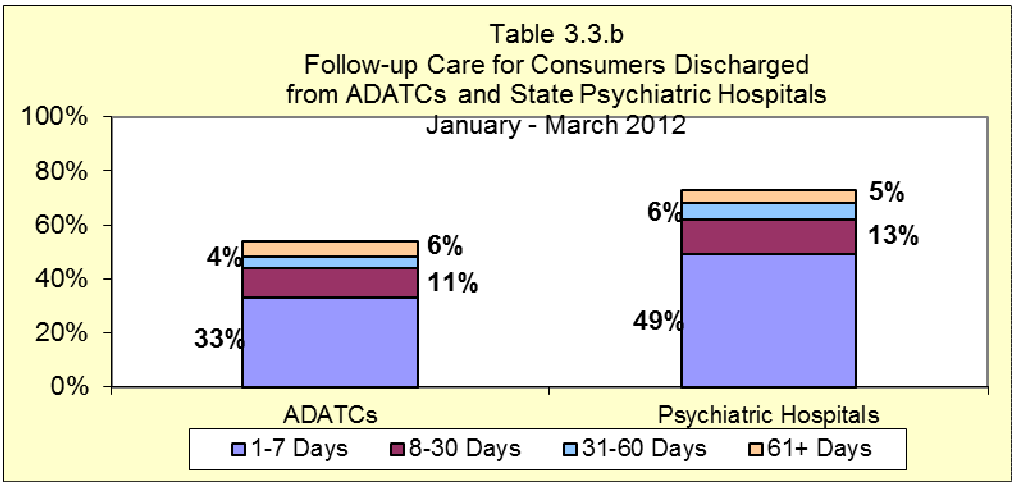
Moving from state facilities to community settings requires careful planning and timely follow-up care once the transition has occurred. For individuals with intellectual/developmental disabilities moving from the developmental centers to the community, transition planning begins many months prior to discharge.

Table 3.3.a
Individuals with Intellectual/Developmental Disabilities (I/DD) Discharged
from the General Population of the State Developmental Centers
CY 2012

Time Period	Number of Individuals Moved to Community[3]	Type of Community Setting
January – March 2012	1	1 to other setting
April – June 2012	1	1 to other setting
July – September 2012	3	2 to ICF-MR group home 1 to other setting
October – December 2012	4	3 to ICF-MR group home 1 to Family Home

Source: Data from state developmental centers (J. Iverson Riddle Center, Murdoch Center and Caswell Center).

Follow-up care in the community within seven days of discharge from ADATCs and state psychiatric hospitals is considered best practice, as it supports continuity of care to sustain progress gained while in inpatient care.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data January 1 – March 31, 2012; Medicaid and State Service Claims Data (for claims paid through July 31, 2012).

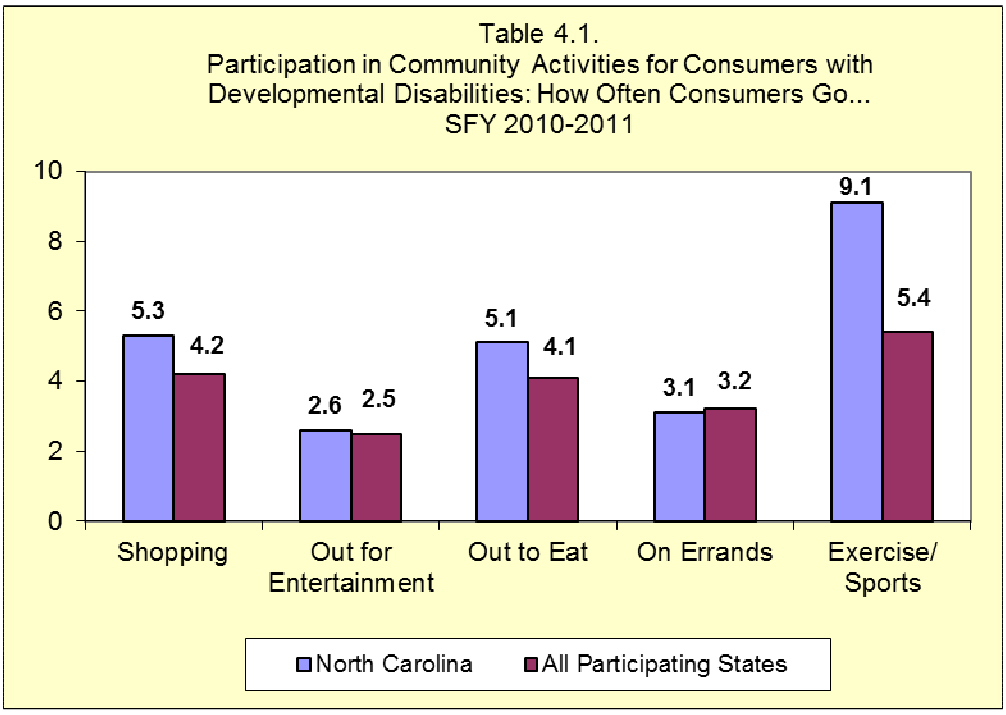
[3] This number does not include persons discharged from specialty programs or respite care in the developmental centers.

Domain 4: Consumer-Friendly Outcomes

Recovery and stability for a person with disabilities means having independence and control over one's own life, being considered a valuable member of one's community and being able to accomplish personal and social goals.

Measure 4.1: Outcomes for Persons with Intellectual/Developmental Disabilities

Being included as a member of the community is an important goal of services and supports for individuals with intellectual/developmental disabilities. The table below indicates the average number of times per month individuals participate in the noted activities.

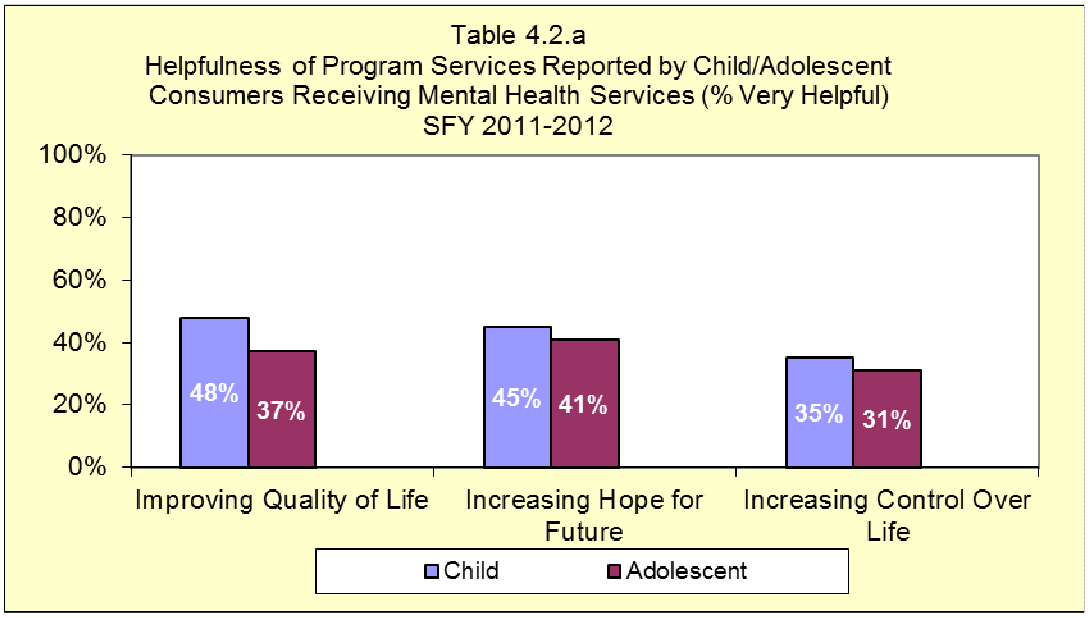


SOURCE: National Core Indicators State Report: North Carolina. Project Year 2010-11.

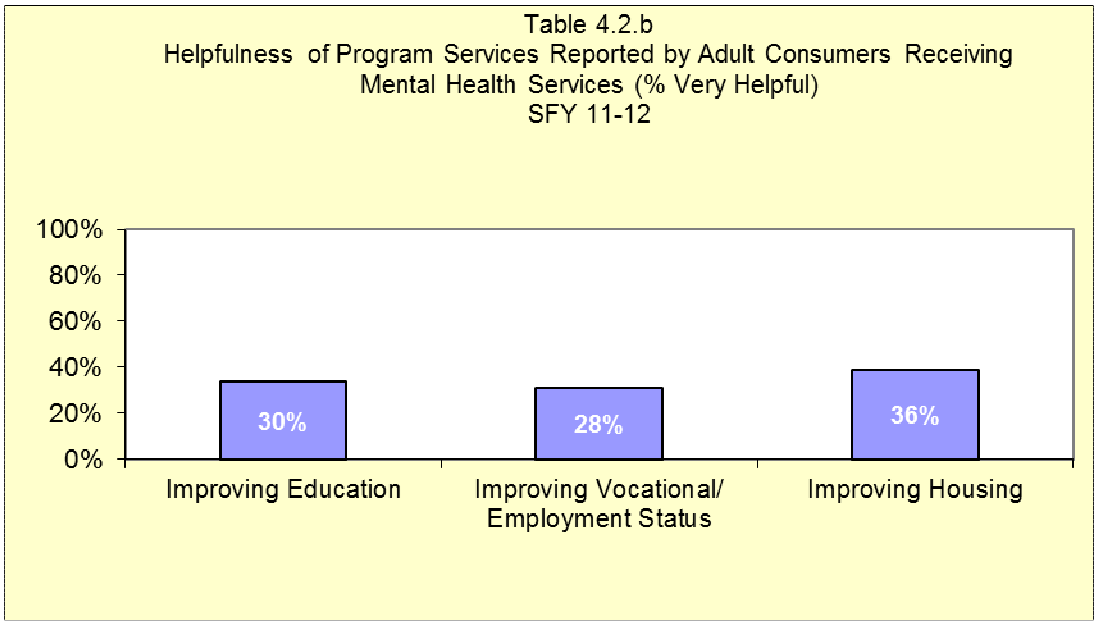
Measure 4.2: Outcomes for Persons with Mental Health Disorders

For children and adolescents with severe emotional disturbances and their families, a sense of hope and control over life is important for recovery. Table 4.2.a on the next page, shows how adolescents (ages 12-17) and parents of children ages six to eleven perceive the helpfulness of the services they received.

For adults with mental illness, housing and employment are central to regaining personal control of one's life. Table 4.2.b on the next page, shows how adults perceived the impact of services in improving these areas of their lives.



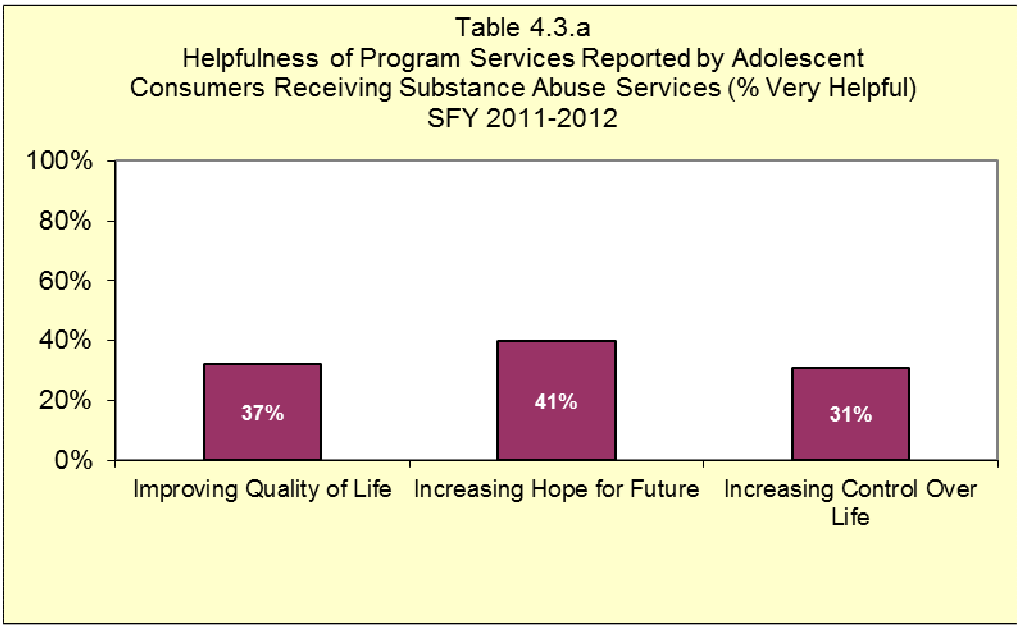
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS): 3-Month Update Interviews conducted July 1, 2011 - June 30, 2012.



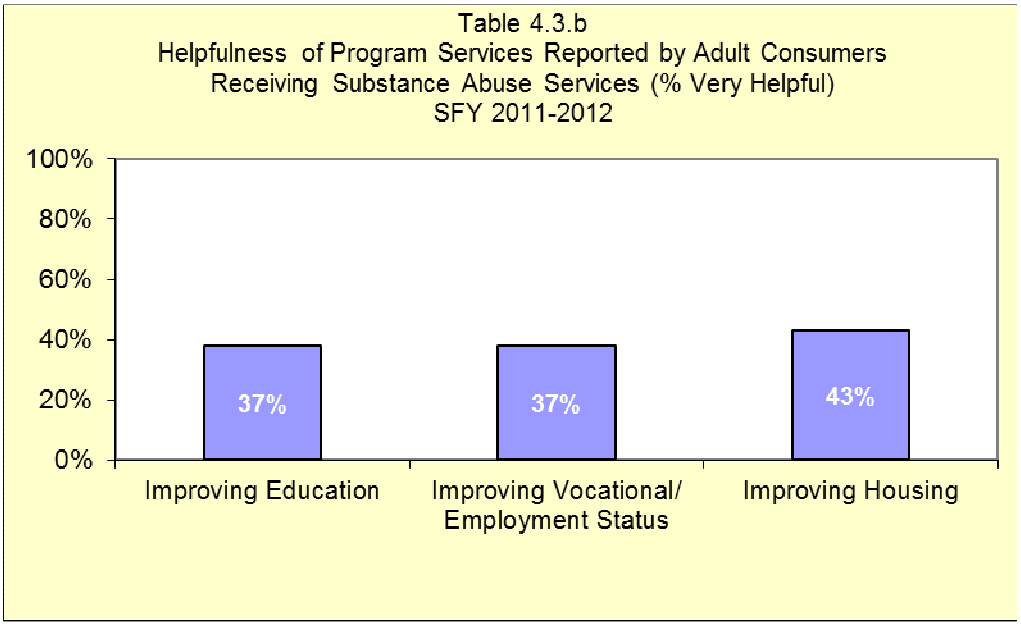
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS): 3 Month Update Interviews conducted July 1, 2010 - June 30, 2011.

Measure 4.3: Outcomes for Persons with Substance Use Disorders

National measures for persons with substance use problems focus on eliminating the use of alcohol and other drugs in order to improve consumers' well-being, social relationships and activities. Successful initiation and engagement in services with this population can have positive results in a short time, as shown on the next page in Tables 4.3.a and 4.3.b.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. 3 Month Update Interviews conducted July 1, 2011 - June 30, 2012.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. 3 Month Update Interviews conducted July 1, 2011 - June 30, 2012.

Domain 5: Quality Management Systems

The Department has expanded the 1915 (b)/(c) Medicaid Waiver, which restructures management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders. The goal of this restructuring is to contain the costs of the Medicaid program while ensuring access to high quality services for those in need. As of February 2013, nine Local Management Entities (LMEs) /Managed Care Organizations (MCOs) have implemented a managed care delivery

system for individuals who are Medicaid eligible, in addition to continuing their responsibilities to manage and ensure high quality care for individuals who receive mh/dd/sa services funded by State appropriations and federal block grants. The Department of Health and Human Services Strategic Plan, submitted to the Joint Legislative Oversight Committee on Health and Human Services, defines how the Division and the Division of Medical Assistance will monitor and evaluate this initiative.[4]

Measure 5.1: External Quality Review of the 1915 (b)/(c) Medicaid Waiver Sites

Previous reports have described the primary oversight and evaluation mechanisms, including intra-departmental monitoring teams, regular review of performance data, feedback from providers and consumers, and performance improvement projects.

In addition to the Department's annual reviews, federal requirements for waiver oversight include having an external agency conduct independent on-site reviews of each Local Management Entity/Managed Care Organization annually. DHHS selected the Carolina Center for Medical Excellence (CCME) through an RFP process to conduct these external quality reviews. During its reviews, CCME completes the following tasks:

- Evaluation of the LME/MCOs compliance with federal and state regulations for the waiver
- Validation of performance measures reported by each LME/MCO to DHHS
- Validation of information used to support each LME/MCO's selection of and progress on performance improvement projects
- Validation of encounter claims data submitted by each LME/MCO to DHHS, including its completeness, accuracy, and use for quality monitoring and trend analysis

CCME submits a technical report to DHHS on the basis of its review, which provides detailed information on its findings. The report includes information about the quality, timeliness and accessibility of care furnished by the LME/MCO, assesses its strengths and weaknesses, and identifies opportunities for improvement.

The LME/MCOs that implemented the waiver by July 2012 will be due for their external quality reviews in July 2013. LME/MCOs that implemented the waiver after that will be due for their external quality reviews the following year. A status update on the Medicaid waiver implementation will be provided in the next Semi-Annual Statewide System Performance Report (October 2013).

Measure 5.2: Gold Star Rating and Monitoring of Service Providers

Numerous monitoring efforts are conducted by LME/MCOs, the Division of Medical Assistance (DMA), the Division of Health Service Regulation (DHSR) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH). As the transition to a managed care system evolved, legislation was passed that requires the Department to implement a standardized monitoring process that reduces duplication and increases coordination among the oversight agencies, with the goal of ensuring a comprehensive network of quality providers. The Department is adopting a monitoring process based on the Gold Star model used by Cardinal

[4] The Joint Legislative Oversight Committee on Health and Human Services has received a copy of this Strategic Plan on October 1, 2011.

Innovations since 2005. It consists of a variety of tools that measure each provider agency in such areas as notifying individuals of their rights, health and safety measures, records and documentation, adherence to service definition requirements and staff qualifications. Provider performance on these tools results in a "rating" or profile designation as Routine, Preferred, Exceptional or Gold Star.

The Gold Star Rating and Monitoring process was first introduced to LME/MCOs in July 2012. All LME/MCOs have received preliminary training and standardized tools. As LME/MCOs implement the Waiver, they will adopt the Gold Star model for overseeing their provider network.

Domain 6: System Efficiency and Effectiveness

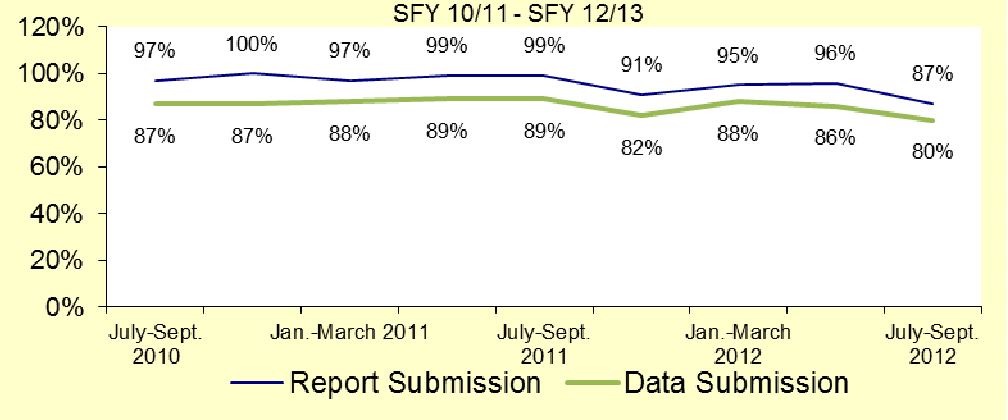
System efficiency and effectiveness refers to the capacity of the service system to use limited funds wisely -- to serve the persons most in need in a way that ensures their safety and dignity while helping them to achieve recovery and independence. An effective service system is built on an efficient management system, key features of which include good planning, sound fiscal management and thorough information management.

Making good decisions and managing scarce resources requires the ability to get accurate, useful information quickly, easily and regularly. The *DHHS-LME Performance Contract* serves as the Division's vehicle for evaluating LME/MCOs efficiency and effectiveness. It includes a standardized scope of work detailing the components of each function that the LME/MCOs are expected to perform, reporting expectations, and critical system performance indicators.

Measure 6.1: Business and Information Management

Consumer data reported by the LME/MCOs is coupled with claims data to generate the information that the Division uses to evaluate local and state system performance and to keep the Legislature informed of system progress through this report. LME/MCOs compliance is critical to state and local efforts to manage the service system. The *DHHS-LME Performance Contract* includes requirements for timely, complete and accurate submission of consumer and program information. After remaining stable for the past two state fiscal years, LME/MCOs submission of information dropped slightly in SFY 2012, while they were implementing new IT systems for the Medicaid waiver.

Table 6.1
Percentage of Report and Data Submission Standards Met
for DHHS-LME Performance Contract
SFY 10/11 - SFY 12/13



SOURCE: Data from SFY 2010-11 and SFY 2012-13 Quarterly Performance Contract Reports.

Measure 6.2: Performance on System Indicators

The *DHHS-LME Performance Contract* includes a variety of performance indicators, each with a standard based on the previous year's achievements. The regular reporting of community progress on these indicators assists local and state managers in identifying areas of success and areas in need of attention, as well as holds every part of the system accountable for progress toward the Division's goals for a high quality service system.

Table 6.2: Number of LME/MCOs Meeting Standard on System Performance Indicators 1st Quarter SFY 2012-2013
(N=18 LME/MCOs)

System Performance Indicator	Sub-Measure	Number of LME/MCOs That Met the Performance Standard
Timely Access to Care	Urgent	8
	Routine	10
Services to Persons in Need	Adult MH	10
	Child MH	8
	Adult DD	11
	Child DD	5
	Adult SA	10
	Adolescent SA	9
Timely Initiation/ Engagement in Services	MH: 2 Visits in 14 Days	11
	MH: 4 Visits in 45 Days	10
	SA: 2 Visits in 14 Days	13
	SA: 4 Visits in 45 Days	13
Timely Support for People with IDD	First Service within 30 Days	6
Effective Use of State Psychiatric Hospitals	1-7 Days of Care	17
State Psychiatric Hospital Readmissions	30-Day Readmissions	16
	180-Day Readmissions	10
Timely Follow-Up After Inpatient Care	ADATCs: Seen in 1-7 Days	3
	State Psychiatric Hospitals: Seen in 1-7 Days	2

Domain 7: Prevention and Early Intervention

Prevention and early intervention activities are designed to minimize the occurrence of mental illness, developmental disabilities, and substance abuse whenever possible and to minimize the severity, duration, and negative impact on persons' lives when a disability cannot be prevented.

Measure 7.1: Controlled Substances Reporting System

In response to the epidemic of prescription drug overdose in the nation and in North Carolina, the Legislature passed legislation in 2005 to create a prescription monitoring program. The Controlled Substances Reporting System (CSRS) is intended to identify individuals misusing controlled substances and refer them to treatment and to identify and stop diversion of prescription drugs without impeding their appropriate medical use.

Pharmacies and other dispensers are required to report all controlled substance prescriptions to the CSRS within one week of being dispensed. The CSRS also allows prescribers and dispensers to check the database to ensure patients are not receiving multiple prescriptions from numerous resources. This feature helps to prevent NC residents from being prescribed potentially lethal amounts or dangerous combinations of medications.

North Carolina ranks in the top one-third of states in the nation for prescription drug deaths. As seen in the chart below, unintentional deaths in North Carolina in which specific controlled substances are a factor increased from approximately 200 in 2000 to over 878 in 2011, which represents a 250% increase over 10 years.

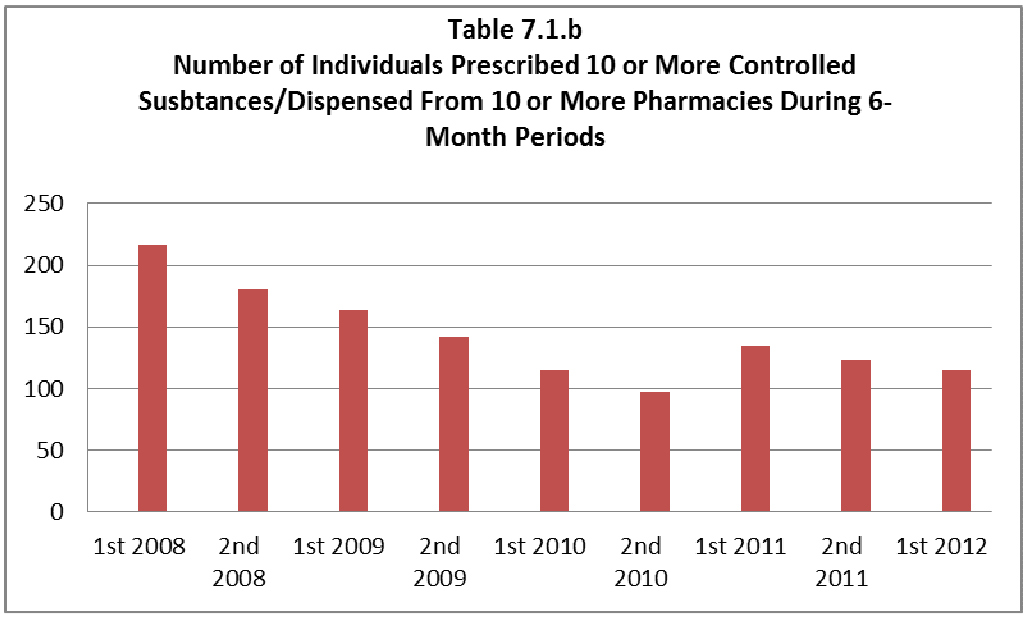
* 2012 figure is extrapolated based on 444 deaths during the period of January – June, 2012. SOURCE: North Carolina State Medical Examiner's Office

NC Controlled Substance Reporting System Prescription Facts:

- Over 19 million controlled substance prescriptions are recorded annually in the NC CSRS (current total is approximately 98 million).
- Over 2.6 million North Carolinians received prescriptions for controlled substances from January-June 2012, accounting for nearly 400 million doses.

- There are 11,729 prescribers (30% of the total) and 2900 dispensers (27% of the total) registered to use the system.
- Over 3000 queries are made of the system daily by these practitioners.

The following chart depicts individuals who received Schedule II, III or IV medications from at least 10 different prescribers and from 10 different pharmacies during six month intervals from 2008 through the first half of calendar year 2012.



SOURCE: Drug Control Unit, Community Policy Management, DMHDDSAS

Key changes since the CSRS was implemented in 2007:

- Over the past three years there has been a steady increase in providers registered for and using the CSRS.
- The number of drug seeking patients, particularly those meeting the strictest definitions of drug seeking behaviors, has dropped substantially since the program started.
- Admissions to substance abuse treatment facilities for controlled substances abuse rose from less than 2% in 2000 to more than 13% in 2011.

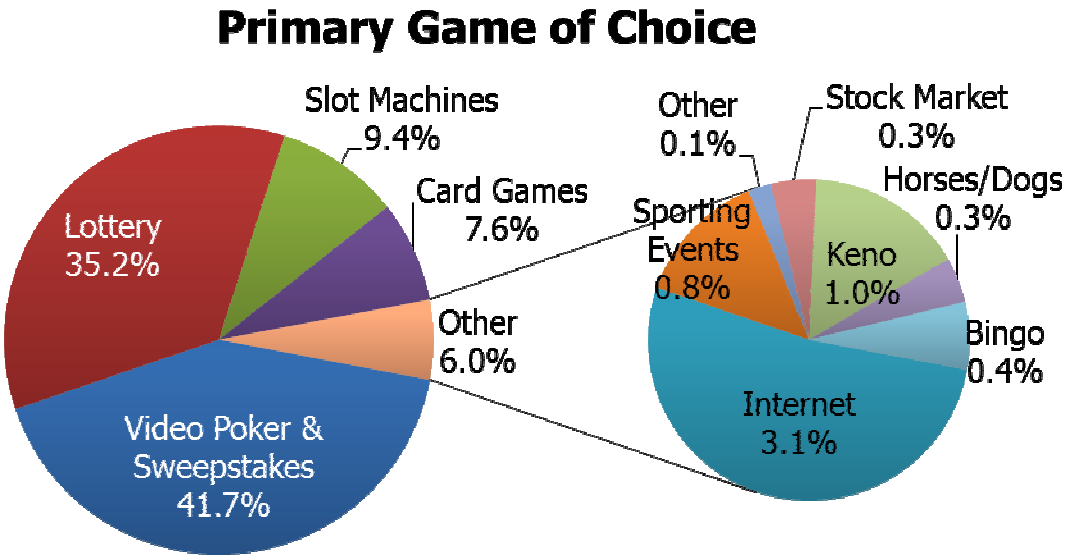
Measure 7.2: Problem Gambling

Each year approximately 2.1% of adults in North Carolina experience gambling problems that can lead to financial difficulty, including bankruptcy, as well as strained relationships, excessive alcohol use and suicide.

The North Carolina Problem Gambling Program was developed in 2006 to address these issues and to provide assistance to individuals suffering from problem gambling, along with their families. The legislation creating the NC Education Lottery requires one million dollars be transferred each year to the North Carolina Department of Health and Human Services (DHHS) for the support of problem gambling prevention and education, outreach and treatment.

During fiscal year 2012, the helpline answered over 6,563 calls with 991 individuals receiving treatment services from treatment professionals. Of the calls received, 74% were from the

individual with gambling issues and 26% were family and friends of problem gamblers. Among those seeking assistance, 42% reported their primary problem gambling activity to be sweepstakes and video poker, followed by lottery games and slot machines.

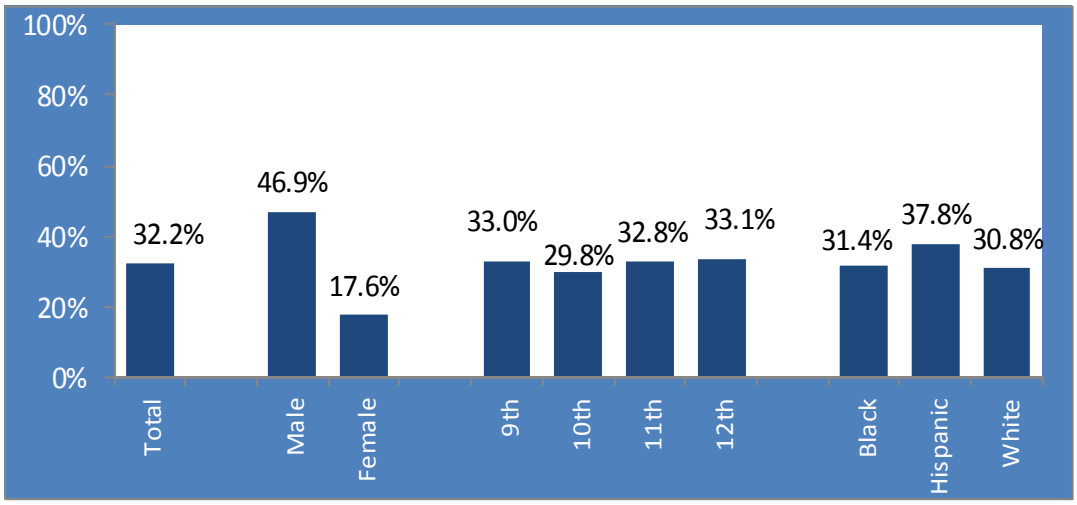


SOURCE: FY 2012 North Carolina Problem Gambling Helpline Report, Presented by Bensinger, DuPont & Associates.

SOURCE: FY 2012 North Carolina Problem Gambling Helpline Report, Presented by Bensinger, DuPont & Associates.

Almost one-third of high school students reported gambling during the past year with ninth graders gambling at the same rate as twelfth graders.

2011 YRBS: Demographics of N.C. High School Gamblers



SOURCE: NC Youth Risk Behavior Surveillance (YRBS) Survey 2011, Atlanta, GA: CDC; 2011

Effective prevention and early intervention programs present the most significant opportunities to reduce the burden of problem gambling. The NC Problem Gambling Program offers awareness and prevention programs across North Carolina at the middle school, high school and college level.

Appendix A: Description of Data Sources

Domain 1: Access to Services

Table 1.1.a Persons in Need (*Prevalence Rates*): The estimates of the percentage of individuals who experience a mental health, developmental, and/or substance abuse disability each year come from the following sources:

Population Data: NC Office of State Budget and Management (OSBM).
http://www.osbm.state.nc.us/demog/countytotals_singleage_2012.html. Last updated: 5/8/12
Downloaded: 8/22/12

MH Prevalence Rates: Prevalence rates for children with Serious Emotional Disturbance (SED) and adults with Serious Mental Illness (SMI) in North Carolina were prepared for the Center for Mental Health Services (CMHS) by the National Association of State Mental Health Program Directors Research Institute (NRI) State Data Infrastructure Coordinating Center (SDICC), September 2012, for the Mental Health Block Grant.

- **Children**: URS Table 1: Number of Children with Serious Emotional Disturbance, ages 9-17, by State 2011. Note: 12% is the midpoint (11%-13%) for the LOF=60 range (SED with substantial functional impairment). The same rate was applied to children under age 9.

- **Adults**: URS Table 1: Number of Persons with Serious Mental Illness, age 18 and older, by State, 2011 = 5.4%

NC Substance Abuse Prevalence Rates Source: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2009 and 2010, published March 2012. Table B.20, Dependence on or Abuse of Illicit Drugs or Alcohol in Past Year, by Age Group and State: Percentages, Annual Averages Based on 2009 and 2010 NSDUHs. Prevalence rate for adolescents (ages 12-17) is 5.89%. Prevalence for adults (ages 18-25) is 17.94% and for adults (ages 26+) is 6.37%. Total (age 12+) = 7.82%.

I/DD Prevalence Rates: Larson, S., Lakin, C., Anderson, L., Kwak, N., Lee, J.H., & Anderson, D. (2000). Prevalence of MR and/or DD: Analysis of the 1994/1995 NHIS-D. MR/DD Data Brief, April 2000, Vol 2, No. 1. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration. The NHIS-D is the National Health Interview Survey (NHIS) Disability Supplement used to estimate the prevalence of people with MR and/or DD in the US Non-Institutional Population. According to the article, prevalence rates for persons ages 3-5 = 3.84%, ages 6-17 = 3.17%, and ages 18+ = 0.79%. Based on July 2011 NC projected population, and excluding children ages 0-2 who receive services from DPH, 1.30% of the total NC non-institutionalized population and 1.32% of the total population (including persons in institutions) are estimated to have MR and/or DD. If persons ages 0-2 were to be included, the prevalence rate for the non-institutionalized population would be 1.40% and the prevalence rate for the total population would be 1.42%.

Table 1.1.b Percent of Persons in Need and Served (*Treated Prevalence*):
The number of persons in need (the denominator) includes North Carolinians that the state's MH/DD/SA service system is responsible for serving (ages 3 and over for MH and DD, ages 12 and over for SA). The disability of the consumer is based on the diagnosis reported on the service claim. Persons with multiple disabilities are included in all relevant groups.

The percent of persons in need who receive services is calculated by dividing the number of persons who received at least one Medicaid or state-funded service (based on paid claims in the Integrated Payment

Reimbursement System (IPRS) and/or Medicaid claims system) by those estimated to need services. These numbers were calculated by multiplying the most current available statewide prevalence rates for NC for MH, DD, and SA by the July 2012 county population projections for each relevant age group for each county in each LME's catchment area. Caution: Persons served data for Cardinal Innovations Healthcare Solutions, Alamance-Caswell and Piedmont operating centers are self-reported. Persons served for the other Medicaid Waiver sites that have implemented the waiver include IPRS data received for the measurement year and Medicaid data available to DMH/DD/SAS prior to waiver implementation. The data does not include new persons served and paid by Medicaid after the waiver was implemented. Actual numbers of persons served during the year for these LMEs will be higher. Currently, this information is being published in the quarterly *Community Systems Progress Report*.

More information on this report can be found on the web at:
http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.

Table 1.2.a Percentage of Persons Receiving Timely Access to Care: This measure is calculated by dividing the number of persons requesting routine (non-urgent) care into the number who received a service within the required time period (14 calendar days) and multiplying the result by 100. The information comes from data submitted by LMEs to the Division. The Division verifies the accuracy of the information through annual on-site sampling of records. Currently, this information is being published in the quarterly *Community Systems Progress Report*. More information on this report can be found on the web at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.

Table 1.2.b Service Received in Time Frame that Met Needs of Consumers: The data presented in this table comes from clinician-to-consumer initial interviews that occurred between July 1, 2011 and June 30, 2012 through the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS). This web-based system collects information on a regular schedule from all persons ages 6 and over who receive enhanced mental health services and 12 and over who receive substance abuse services. More information on NC-TOPPS, including annual reports on each age-disability group, can be found at http://www.ncdhhs.gov/mhddsas/nc-topps/index.htm. Within age groups, mental health and substance abuse consumers overlap due to co-occurring disabilities.

Domain 2: Individualized Planning and Supports

Tables 2.1.a Choice of Providers Among Persons With Mental Health And Substance Use Disorders: This information comes from NC-TOPPS, described in Table 1.2.b above.

Tables 2.1.b Choice Over Daily Decisions for Persons With Intellectual/Developmental Disabilities: The data presented in these tables are from in-person interviews with North Carolina consumers in project year 2010-11, as part of the National Core Indicators Project (NCIP). This project collects data on the perceptions of individuals with intellectual and/or developmental disabilities and their parents and guardians. The interviews and surveys ask questions about service experiences and outcomes of individuals and their families. More information on NCIP, including reports comparing North Carolina to other participating states on other measures, can be found at: http:www.nationalcoreindicators.org.

Tables 2.2.a Family Involvement for Consumers with Mental Health and Substance Use Disorders: This information comes from 3-month update interviews conducted in SFY 2011-12 in NC-TOPPS, described in Table 1.2.b above.

Tables 2.2.b Input into Planning Services and Supports for Persons with Intellectual/Developmental Disabilities: This information comes from NCIP, described in Tables 2.1.b above.

Domain 3: Promotion of Best Practices

Tables 3.1.a – 3.1.c Number of Individuals Participating in Certain Evidence-Based and Best Practices:

Information on numbers served in certain services comes from claims data, as reported to Medicaid and the Integrated Payment and Reporting System (IPRS). Caution: Data for recent quarters is incomplete

due to billing lag. Persons served for Medicaid Waiver sites that have implemented the waiver include IPRS data received for the measurement year and Medicaid data available to DMH/DD/SAS prior to waiver implementation. The data does not include services paid by Medicaid after the waiver was implemented. Actual numbers of persons receiving services since waiver implementation will be higher.

Table 3.2.a Short Term Care in State Psychiatric Hospitals: The data come from the Division's Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) discharges for the period of July 1 - September 30, 2012. The HEARTS data include demographic, diagnostic, length of stay and treatment information on all consumers who are served in state-operated facilities. Lengths of stay are calculated by subtracting the date of admission from the date of discharge. The percents for each length of stay grouping (1-7 days, 8-30 days, 30-365 days, and over 365 days) are calculated by dividing the total number of discharges during July 1- September 30, 2012 into the number of discharges in each length of stay grouping and multiplying by 100.

Table 3.2.b Admissions to ADATC Facilities: ADATCs are critical resources, providing services to individuals with co-occurring substance abuse and mental health disorders that require 24-hour inpatient hospitalization. The data come from the Division's HEARTS data for SFY 2007 through SFY 2012 as reported in the Consumer Data Warehouse (CDW).

Table 3.3.a Follow-up Care for Consumers with Intellectual/Developmental Disabilities Discharged from the General Population of the State Development Centers: These data come from reports submitted quarterly by the developmental centers to the NC Division of State Operated Healthcare Facilities. The numbers do not include persons discharged from specialty programs (such as programs for persons with both mental retardation and mental illness) or persons who were discharged after receiving respite care only.

Table 3.3.b Follow-up Care for Consumers Discharged from ADATCs and State Psychiatric Hospitals: The data come from HEARTS direct discharges during the period January 1 – March 31, 2012 and Medicaid and State Services paid claims data through July 31, 2012. Discharges to other state-operated facilities and the criminal justice system are not included. The time between discharge and follow-up care is calculated by subtracting the date of discharge from the date of the first claim for community-based service that occurs after the discharge date. The percents of persons seen within 7 days, 8-30 days, 30-60 days and greater than 60 days are calculated by dividing the total number discharged during the period into the number in each of the groupings of time to follow-up care. Caution: Persons served for Medicaid Waiver sites that have implemented the waiver include IPRS data received for the measurement year and Medicaid data available to DMH/DD/SAS prior to waiver implementation. The data does not include services paid by Medicaid after the waiver was implemented. Actual numbers of persons receiving services since waiver implementation will be higher.

Domain 4: Consumer Outcomes

Tables 4.1 Participation in Community Activities for Persons With Intellectual/Developmental Disabilities: This information comes from NCIP, previously described in Tables 2.1.b.

Tables 4.2 and 4.3 Helpfulness of Program Services for Individuals With Mental Health And Substance Use Disorders: This information comes from the 3-month update interviews conducted in SFY 2011-12 in NC-TOPPS, previously described in Table 1.2.b.

Domain 6: System Efficiency and Effectiveness

Table 6.1 Business and Information Management: Table 6.1 includes timely, complete and accurate submission of information required in the *DHHS-LME Performance Contract* over the last state fiscal year. This report tracks LME performance in submitting required data and reports to the Division. Some requirements are quarterly while others are semi-annual or annual requirements. For these reasons, the number of requirements included in the denominators for Table 6.1 fluctuates over the four fiscal quarters

represented. More information on the *DHHS-LME Performance Contract,* including the quarterly reports, can be found at: http://www.ncdhhs.gov/mhddsas/performanceagreement/.

Table 6.2 Number of LME/MCOs That Met Performance Standards: The data used in this measure was received on October 30, 2012 for the period of July 1- September 30, 2012. Currently, this information is being published in the quarterly *Community Systems Progress Report*. More information on this report can be found on the web at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.

Domain 7: Prevention and Early Intervention

Table 7.1.a Unintentional Deaths in North Carolina Due to Controlled Substances: This data was taken from reports completed by the North Carolina Office of the Medical Examiner and includes unintentional deaths from which specific controlled substances were either a contributing or causal factor.

Table 7.1.b Number of Patients with 10 or More Prescriptions from 10 or More Pharmacies: This information was taken from data collected by the Drug Control Unit, Community Policy Management, DMHDDSAS.

Table 7.2 The North Carolina Problem Gambling Program (NCPGP): Problem game of choice and length of gambling problem data was retrieved from FY 2012 North Carolina Problem Gambling Helpline Report, Presented by Bensinger, DuPont & Associates. Demographics of North Carolina high school students who gamble was determined by The NC Youth Risk Behavior Surveillance (YRBS) Survey 2011, Atlanta, GA: CDC; 2011.